

CHIEF COMPLAINT: (WHAT IS THE REASON FOR YOUR VISIT TODAY?)

HISTORY OF PRESENT ILLNESS:

LOCATION: (WHERE IS YOUR WOUND LOCATED?)

DURATION: (HOW LONG HAVE YOU HAD THE WOUND?)

CONTEXT: (HOW DID YOUR WOUND OCCUR OR DEVELOP?)

ASSOCIATED SIGNS/SYMPTOMS: DESCRIBE ANY SIGNS OR SYMPTOMS OF YOUR WOUND (SUCH AS, DRAINAGE, ODOR, NUMBNESS, ETC.)

TIMING: (DO YOU HAVE PAIN IN OR AROUND THE WOUND?) No Yes

IF YES, IS THE PAIN CONSTANT (*HURTS ALL THE TIME*) OR INTERMITTENT (*COMES AND GOES*)?

QUALITY: (DESCRIBE YOUR PAIN BY CHECKING ALL THAT APPLY BELOW)

- ACHING BURNING THROBBING STABBING SHOOTING SHARP DULL HEAVY
 CRAMPING EXHAUSTING SPLITTING TENDER EASY TO PINPOINT DIFFICULT TO PINPOINT

MODIFYING FACTORS: (DESCRIBE OR LIST ANY CONDITIONS OR ACTIVITIES THAT IMPACT YOUR WOUND, SUCH AS PAIN WHEN WALKING OR RAISING YOUR LEG)

** HAS YOUR WOUND EVER HEALED AND THEN RE-OPENED? No Yes

** HAVE YOU HAD ANY LAB WORK DONE IN THE PAST MONTH? No Yes; IF YES, WHERE: _____

** HAVE YOU HAD ANY TESTS FOR CIRCULATION IN YOUR LEGS? No Yes; IF YES, WHERE: _____

** WHO ORDERED ABOVE TESTS? LAB _____ CIRCULATION: _____

** HOW HAVE YOU BEEN TAKING CARE OF YOUR WOUND?

** INFORMATION IS NOT COLLECTED IN THE CLINICAL DATABASE



ALLERGIES: (LIST ALL KNOWN ALLERGIES AND REACTIONS)

NO KNOWN ALLERGIES LATEX / RUBBER TAPE IODINE

FOOD (LIST): _____

MEDICATIONS (LIST): _____

OTHER: (LIST): _____

SEVERITY: CIRCLE THE NUMBERS THAT BEST DESCRIBE YOUR CURRENT LEVEL OF PAIN

Tell Us If You Have Pain

10		Worst Possible Pain (El peor dolor)
9		Very Severe Pain (Un dolor muy fuerte)
8		Severe Pain (Un dolor fuerte)
7		Moderate Pain (Un dolor moderato)
6		Mild Pain (Un dolor suave)
5		Mild Pain (Un dolor suave)
4		Mild Pain (Un dolor suave)
3		Mild Pain (Un dolor suave)
2		Mild Pain (Un dolor suave)
1		Mild Pain (Un dolor suave)
0		No Pain (Sin dolor)

ADVANCED DIRECTIVES & INSTRUCTIONS: (CHECK ALL THAT APPLY)

I HAVE AN ADVANCE DIRECTIVE I HAVE A LIVING WILL

ADVANCE DIRECTIVE MATERIALS WERE PROVIDED TO ME

I HAVE A COPY OF MY LIVING WILL FOR THE HOSPITAL

I HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE

I DO NOT WANT TO BE RESUSCITATED

REVIEW OF SYSTEMS / PAST MEDICAL & SURGICAL HISTORY

CONSTITUTIONAL (GENERAL HEALTH)			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Active			
Fatigue (<i>tired all of the time</i>)			
Fever			
Loss of Appetite			
Marked Weight Change			
Sedentary (<i>low activity level</i>)			
Night Sweats			
MEDICAL HISTORY	YES	NO	COMMENTS
Influenza (<i>Flu</i>) Vaccine Current			
Pneumonia Vaccine Current			
Tetanus Vaccine Current			
Sleep Apnea			
ALLERGIC / IMMUNOLOGIC			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Rhinitis (<i>inflamed nasal passage</i>)			
Hay Fever			
MEDICAL HISTORY	YES	NO	COMMENTS
AIDS / HIV			
Lupus			
Pyoderma Gangrenosum			
Reynaud's Disease			
Rheumatoid Arthritis			
CARDIOVASCULAR (CENTRAL / PERIPHERAL)			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Dyspnea on exertion (<i>shortness of breath with activity</i>)			
Edema (<i>swelling</i>)			
Intermittent Claudication (<i>pain on exertion, i.e. walking to mailbox</i>)			

Orthopnea (<i>shortness of breath when lying down</i>)			
Palpitations			
MEDICAL HISTORY	YES	NO	COMMENTS
Congestive Heart Failure			
Coronary Artery Disease (<i>CAD</i>)			
Deep Vein Thrombosis (<i>clot in the vein</i>)			
Hyperlipidemia (<i>High cholesterol</i>)			
Hypertension (<i>High blood pressure</i>)			
Murmur			
Myocardial Infarction (<i>Heart attack</i>)			
Peripheral Vascular Disease			
Rheumatic Fever			
Vasculitis			
SURGICAL HISTORY	YES	NO	COMMENTS
Coronary Artery Bypass Surgery			
Greenfield Filter			
Left Ventricular Assist Device			
Pacemaker/Defibrillator			
Peripheral Bypass surgery			
Stent Placement			
Subfascial endoscopic perforator surgery (<i>SEPS</i>)			
Valve Replacement			
Vein Stripping			
EAR / NOSE / MOUTH / THROAT			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Hearing Loss / Aid			
Otalgia (<i>ear ache</i>)			
Dental Problems			
Painful or Swollen Lymph Nodes			
MEDICAL HISTORY	YES	NO	COMMENTS
Barotrauma (<i>damage to ear drum</i>)			
Sinusitis			
Tinnitus (<i>ringing in ears</i>)			
SURGICAL HISTORY	YES	NO	COMMENTS
Myringotomy (<i>incision in eardrum</i>)			
Tube Placement (<i>in ear</i>)			
EYES			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Blurred Vision			
Dry Eyes			
Vision Changes			
Glasses / Contacts			
MEDICAL HISTORY	YES	NO	COMMENTS
Cataracts			
Glaucoma			
Retinopathy (<i>damage to the retina</i>)			
SURGICAL HISTORY	YES	NO	COMMENTS
Other			
ENDOCRINE			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cold Intolerance			

Heat Intolerance			
Polydypsia (<i>Excessive thirst</i>)			
Polyuria (<i>Excessive urination</i>)			
MEDICAL HISTORY	YES	NO	COMMENTS
Gestational Diabetes (<i>with pregnancy</i>)			
Thyroid Disease			
Type 1 Diabetes (<i>juvenile onset</i>)			
Type 2 Diabetes (<i>adult onset</i>)			
GASTROINTESTINAL (GI)			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Bowel Incontinence			
Change in Bowel Habits			
Jaundice			
Nausea / Vomiting / Diarrhea			
Loss of Appetite			
MEDICAL HISTORY	YES	NO	COMMENTS
Cirrhosis of the Liver			
Crohn's Disease			
Gastro Esophageal Reflux (<i>GERD</i>)			
Hepatitis (<i>liver infection</i>)			
Special Diet			
Ulcerative Colitis			
SURGICAL HISTORY	YES	NO	COMMENTS
Colectomy (<i>remove part large colon</i>)			
Colostomy			
Ileostomy			
GENITOURINARY (GU)			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Frequency			
Urinary Incontinence			
Pregnant			
MEDICAL HISTORY	YES	NO	COMMENTS
Benign Prostate Hyperplasia (<i>enlarged prostate</i>)			
Dialysis			
End Stage Renal Disease			
Kidney Disease			
Miscarriage			
Prostate Cancer			
Sexually Transmitted Disease			
SURGICAL HISTORY	YES	NO	COMMENTS
Previous OB/GYN Surgery			
HEMATOLOGIC / LYMPHATIC			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Bruising			
Bleeding / Clotting Disorders			
Blood Transfusion			
MEDICAL HISTORY	YES	NO	COMMENTS
Anemia (<i>low blood count</i>)			
Anticoagulant Therapy			
Lymphedema			
Sickle Cell Anemia			
INTEGUMENTARY (HAIR / SKIN / NAILS)			

COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Pruritis (<i>Itching</i>)			
Rash			
Skin Allergies			
Calluses/Corns			
Prone to Skin Tears			
MEDICAL HISTORY	YES	NO	COMMENTS
Malignancy (<i>skin cancer</i>)			
Onchomycosis (<i>nail fungal infection</i>)			
Scleroderma			
MUSCULOSKELETAL			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Backache			
Contractures			
Deformities			
Muscle Pain			
Muscle Wasting			
Muscle Weakness			
Assistive Devices			
MEDICAL HISTORY	YES	NO	COMMENTS
Arthritis			
Gout			
Hip Fracture			
Osteoarthritis			
Osteomyelitis (<i>bone infection</i>)			
Osteoporosis			
Other Fracture			
SURGICAL HISTORY	YES	NO	COMMENTS
Achilles Tendon Lengthening			
Amputation			
Back Surgery			
Foot Surgery			
Implanted Surgical Hardware			
Joint Replacement			
NEUROLOGICAL			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Abnormal Gait			
Dizziness			
Loss of Protective Sensation			
Numbness			
Tingling			
Tremors			
Vertigo (<i>dizziness</i>)			
Weakness			
Headaches			
Paralysis			
Seizures			
Syncope (<i>brief fainting episode</i>)			
MEDICAL HISTORY	YES	NO	COMMENTS
Amyotrophic Lateral Sclerosis (<i>ALS</i>)			
CNS Trauma Injury			
Epilepsy			
Head Injury / LOC			
Multiple Sclerosis			

Stroke			
Transient Ischemic Attack (<i>TIA / mini-stroke</i>)			
PSYCHIATRIC			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Anxiety			
Claustrophobia			
Insomnia			
Nervousness / Tension			
Memory Loss			
MEDICAL HISTORY	YES	NO	COMMENTS
Alzheimer's			
Dementia (<i>loss of mental skills</i>)			
Depression			
RESPIRATORY			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cough			
Hemoptysis (<i>coughing blood</i>)			
Shortness of Breath			
Wheezing			
Oxygen in Use			
MEDICAL HISTORY	YES	NO	COMMENTS
Abnormal Chest X-ray			
Asthma			
Chronic Obstructive Pulmonary Disease (<i>COPD</i>)			
Emphysema			
Pneumonia			
Pneumothorax (<i>collapsed lung</i>)			
Positive TB Test			
Pulmonary Embolus (<i>blood clot in lung</i>)			
Tuberculosis			
Upper Respiratory Infection (<i>URI</i>)			
ONCOLOGIC			
COMPLAINTS & SYMPTOMS	YES	NO	COMMENTS
Cancer			Type:
Receiving Chemotherapy			
Receiving Radiation			
MEDICAL HISTORY	YES	NO	COMMENTS
Cancer			Type:
Received Chemotherapy			
Received Radiation			
Type of Cancer			
FAMILY & SOCIAL HISTORY			
FAMILY HISTORY	YES	NO	COMMENTS
Cancer			
Diabetes			Type I: _____ Type II: _____ Date Onset: _____
Heart Disease			
Hypertension			
Kidney Disease			
Lung Disease			
Mental Illness			
Seizures			
Stroke			
Thyroid Problems			
Tuberculosis			

Social History

Substance Abuse NO YES | DESCRIBE:

Alcohol Use: NEVER RARELY MODERATE DAILY

Tobacco Use: NEVER FORMER LESS THAN 1 PACK PER DAY GREATER THAN 1 PACK PER DAY | YEARS:

Smokeless Tobacco Use: NEVER RARELY MODERATE DAILY

Caffeine Use: NEVER PREVIOUSLY CURRENTLY | TYPE / FREQUENCY:

Illicit Drug Use: NEVER PREVIOUSLY CURRENTLY | TYPE / FREQUENCY:

Occupation:

Marital Status SINGLE MARRIED SEPARATED DIVORCED WIDOWED OTHER:

Children NO YES | IF YES, HOW MANY:

Cultural, Religious or Language Concerns:

Support Systems Lacking:

Transportation Concerns (able to drive, etc.)?:

Able to Care for Self (dressing, bathing, etc.)? No Yes If "No", explain :

MEDICATIONS -- WRITE ON BACK IF MORE ROOM NEEDED

[PLEASE LIST ALL MEDICINES YOU ARE CURRENTLY TAKING -- INCLUDE OVER THE COUNTER, HERBAL & VITAMIN SUPPLEMENTS]

MEDICATIONS	AMOUNT / DOSAGE	HOW OFTEN

NUTRITION ASSESSMENT / SCREEN

HISTORY	YES	NO	ACTION PLAN
Difficulty Chewing or Swallowing [1]			
Do You Need Assistance with Eating [1]			
Have You Had a Weight Loss or Gain > 10 lbs in Past 6 Months [2]			
If Yes, _____ lbs in _____ months			Reason, if known:
Intentional Weight Loss from Program or Medications [1]			
Do You Follow a Special Diet [1]			
Do You Have Any Food Allergies [1]			
Do You Have a Good Appetite [0]			
Do You Have a Fair Appetite [1]			
Do You Have a Poor Appetite [2]			
Do You Take Nutritional Supplements [0]			
Do You Drink Several 8 oz Glasses of Water Each Day [0]			

RISK LEVEL: Low = less than or equal to 2 | High = greater than 3 (Staff Use Only) | **SCORE:**

GENERAL NOTES

PATIENT SIGNATURE: _____ **DATE:** _____ **TIME:** _____
 (OR LEGAL GUARDIAN/POA)

I HAVE REVIEWED THE NEW PATIENT MEDICAL HISTORY WITH THE PATIENT / CAREGIVER AS PART OF THE INITIAL NURSING ASSESSMENT.

NURSE SIGNATURE: _____ **DATE:** _____ **TIME:** _____